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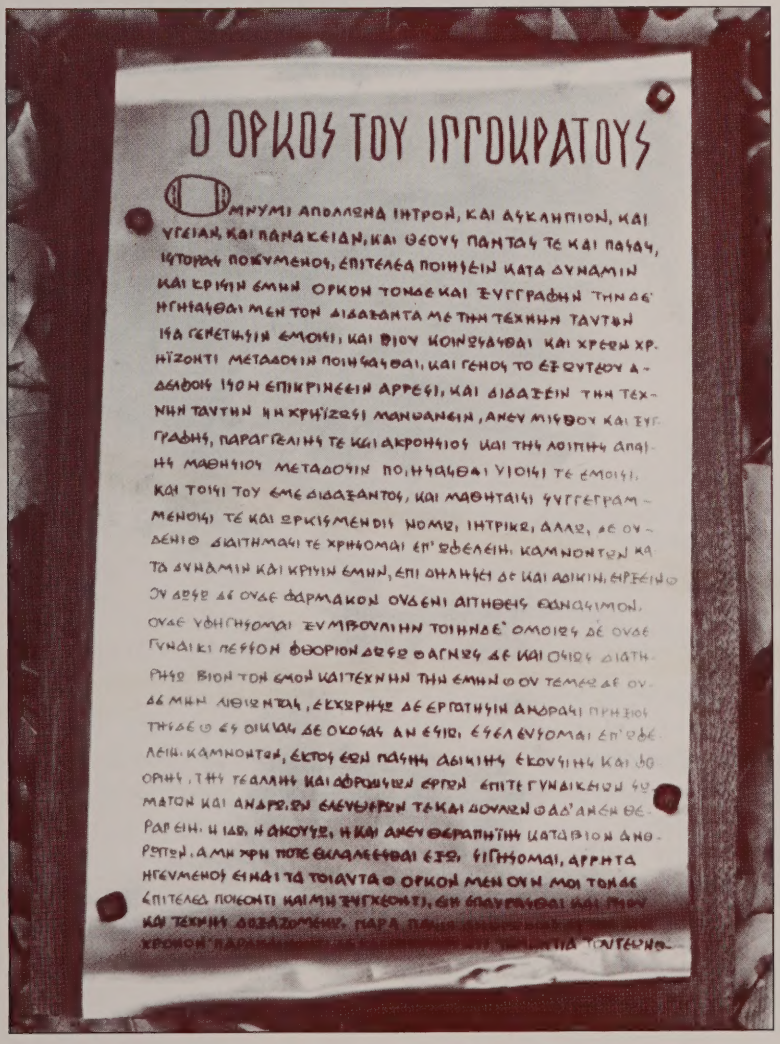
NOVEMBER—DECEMBER 1991

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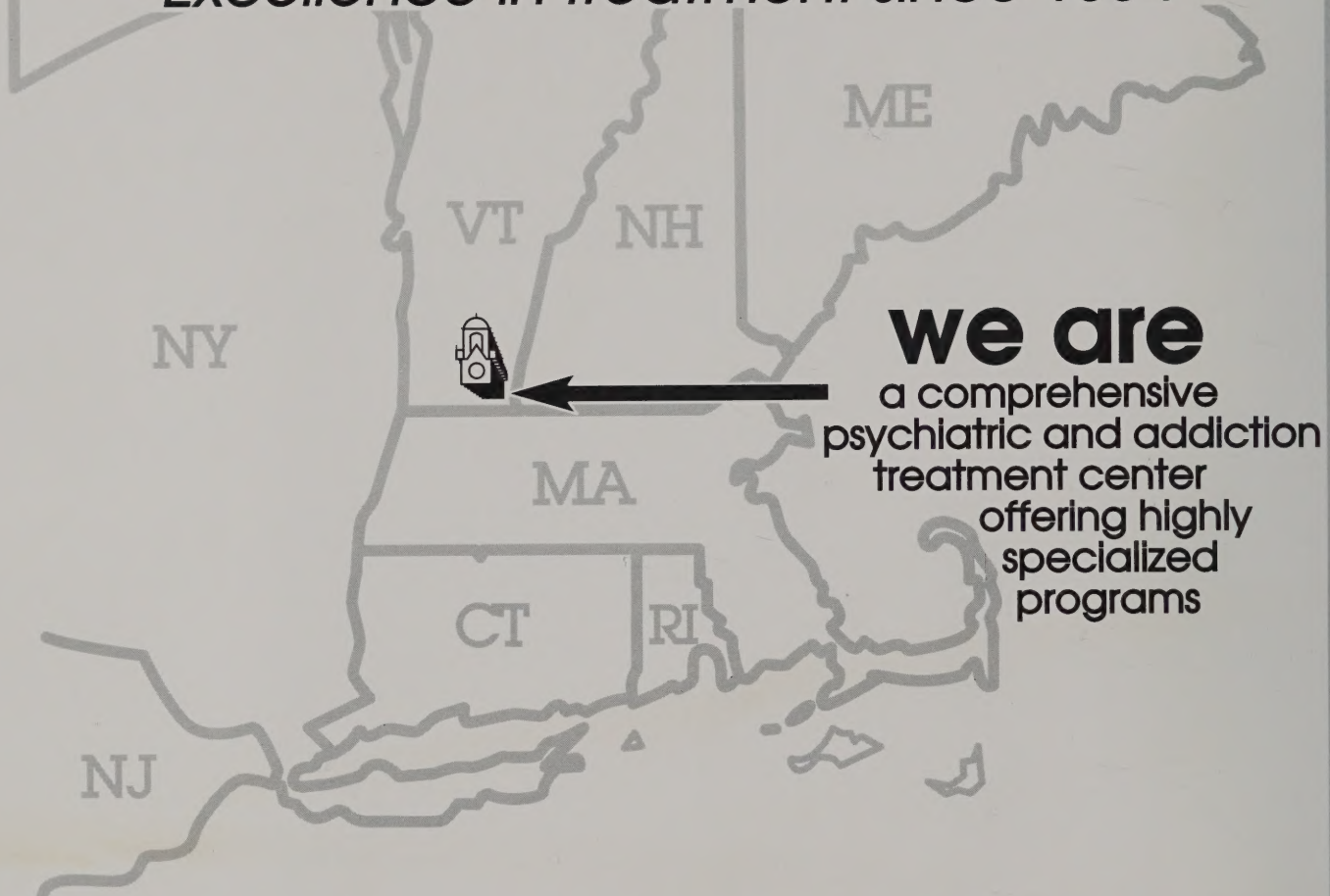


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THE
# Hampden Hippocrat
NOVEMBER—DECEMBER 1991

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The official bulletin for The Hampden District of the Massachusetts Medical Society. Founded in 1942 by Edward P. Bagg, Jr., M.D. and William A. R. Chapin, M.D.

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# HAMPDEN DISTRICT MEDICAL SOCIETY 1991-1992 SEASON

## DISTRICT MEETING

**PLACE:** **THE SPRINGFIELD MARRIOTT**
Corner of Boland & Broadway
Downtown Springfield

**DATE:** Tuesday, January 28, 1992

**BUSINESS MEETING:** 6:00 p.m.

**SOCIAL HOUR:** 7:00 p.m.

**DINNER:** 7:30 p.m.

**SPEAKER:** JOHN LEE CLOWE, M.D., President Elect
American Medical Association

**SUBJECT:** AMA Faces The Issues

**NOTE:** If you must cancel your dinner reservation, please call the HDMS office before noon on January 28th. If the cancellation is not made, you will be BILLED for your dinner.

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# From the Editors

This issue is a reflection on the field of general internal medicine. Originally the "internist" was primarily a diagnostician, whose reasoning powers worked from a history and physical examination to deduce various system failures. As time went on, the internist assumed the guardianship of the evolving pharmacopoeia as well. Internists (perhaps having more time to think about generalities since they did not do surgery) led the "scientific" revolution, demanding that there be credible proof for therapeutic claims. Subspecialties evolved, and continue to evolve today, both from general medicine and the subspecialties themselves. While this tendency is recognizable in other disciplines, this is an example of imitation being the sincerest form of flattery.

Because the internist had a certain breadth of knowledge, and because most ailments are "internal" and increasingly are treated with medications, the internist by default became the physician who was responsible for the general care of the patient. This role, however, is not conceded to the internist; the specialties of family practice, obstetrics/gynecology, emergency medicine, and even pediatrics (they don't let go until the patient turns 25!) all claim this role in some way.

General internal medicine is at a crossroads. It seems to be evolving into an imitation of family practice on one hand, while on the other hand, it is a prerequisite for becoming a "subspecialist". Perhaps because of this split personality it no longer seems to be as attractive a career choice as it once was, and we are seeing fewer medical students entering the pipeline. It will be interesting to see what the next twenty or thirty years will bring. ■

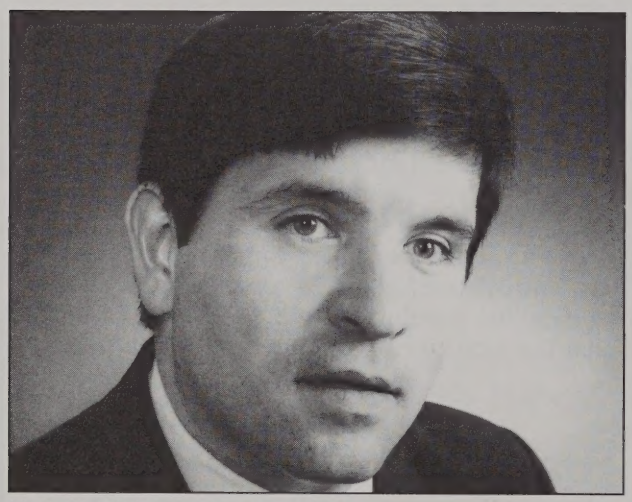
*Brigid Glackin, M.D.*
*Donald J. Higby, M.D.*
*Co-editors*

# Congratulations And Thank You!

Hampden District Medical Society wishes to say a very special thank you to *Robert C. Shepard, M.D.,* winner of a Burberry's of London blazer for recruiting six new members during Mass. Medical Society's Recruit Your Colleagues Membership Drive. *Martin Gimovsky, M.D.* was awarded a Burberry's of London Scarf for his recruitment efforts, and to both these members, Hampden District and Mass. Medical Society both say a heartfelt thank you. ■

# Hang Together... Or Hang Separately!

All physicians-in-training come to a critical juncture in their careers where important decisions need to be made about their future. Already having chosen a major "discipline", the next decision crossroads includes where to set up shop, what type of practice to join and who to associate with.



Mark J. Mullan, M.D., President

Coming out of Baystate Medical Center's Internal Medicine training program in 1982-83 and having decided with my wife (The Pediatrician) to stay in my hometown and not apply for a fellowship, the choices were few: Medical West, solo practice or group practice. My wife chose the former, I took the latter.

Medical West was in the process of beginning a rapid growth spurt and many in the private medical community viewed the plan and its' physicians with fear, suspicion and outright disdain. I could never forget the "hisses" my wife received at the Pediatric graduation dinner when Ed Reiter announced she was going to work at Medical West (Do you remember that, Emil?). These sounds of criticism clearly weren't meant to be taken personally but instead symbolized the bad feelings many established docs had toward the new kids on the block.

Locally over the last several years, a new "villain" has appeared. While Medical West's growth has seemed to stabilize, the Baystate tentacles are reaching out everywhere. The full time staff has grown exponentially and suburban facilities have either been purchased or even started from scratch. "Market share, market share" is the cry from Chestnut Street. Some of the doom-and-gloomers foresee a totally closed hospital staff there in the near future.

The reality is, however, that all sides of this medical equation have much more in common than most care to admit. Practice is changing rapidly and will continue to do so. In this alphabet soup of the insurance world, what with IPA's, group or staff HMO's, PPO's, PRO's, RBRVS, etc., we may have different signatures on our paychecks. But we all deal with the same faceless, and often brainless, governments, and the same kind of administrative bureaucrat dictating the who-what-when-where-why-how of practice to us. And regardless of our place of employ none of us, under any circumstance, has to worry about whether or not President Bush will extend unemployment benefits another twenty weeks.

Whether it be through the Massachusetts Medical Society or any other umbrella, physicians have to work together to solve our many common problems. Malpractice reform, burgeoning government regulation, numerous reimbursement questions such as those with RBRVS and persistent harassment from review organizations of all types are but a few of the many sticky issues we all face. And with the

National Health Insurance locomotive bearing down rapidly upon us, it becomes even more imperative that we speak out in a somewhat unified manner on these issues which will significantly impact both on ourselves personally and on our patients.

Most would agree that the MMS has been an excellent resource for this state's physicians in terms of government relations and legal and actuarial work. Perhaps because it has been perceived by many as simply an extension of "the old boy network" of white, male, private practice/academicians from Eastern Mass., it has never been able to serve as a lightning rod for galvanizing a grass roots movement amongst a profession which is becoming increasingly female and salaried.

I don't pretend to have all the answers as to how to accomplish this. Certainly we can all help by recognizing the special needs, as well as the special abilities, of all physicians across the entire spectrum. From there it would certainly behoove all of us to in some way become more involved in the system, be it through the political process, administrative or board work, or God forbid, even the Hampden District Medical Society.

So instead of waiting for the bomb to drop five or ten years down the road, we all need to contribute our ideas and talents in a way that will enable the physician population to have an effective voice in future changes. I guess you could say that Organized Medicine needs to get organized. ■

Gentleman:

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# Internal Medicine At Western Massachusetts Hospital

*Molly N. Noonan, Ph.D., M.D., is the Director of Western Massachusetts Hospital.*

Chronic care is an increasingly important part of our complex health care system. Whether care is provided in a nursing home, a rehabilitation unit, or at home, general internists are playing key roles in clinical management and coordination of diverse services. At Western Massachusetts Hospital, a chronic care hospital operated by the Department of Public Health, six internists (all but one part time) plan the care for ninety chronically ill patients on specialized care units.

**It is the Internist whose setting of goals, elaboration of options, assessment of prognoses, teaching... and communication... set the tone and agenda of the whole operation.**

Founded in 1910 as a tuberculosis sanitorium, Western Massachusetts Hospital continues to occupy a therapeutic, sunny and breezy hilltop in Westfield. Its role changed with the elimination of old problems and as new public health needs arose. After antibiotics replaced rest and fresh air for treatment of TB the hospital in mid-century specialized in the new high technology radiation treatments and surgical techniques for treatment of cancer. A residency program eventually created enough private practitioners of these arts for the community; the hospital again looked for new public health needs. During the 1970's the area's first physical rehabilitation unit was established, as well as an alcohol rehabilitation unit and one of the nation's first coma units for the care of permanently unconscious patients. As these services were duplicated in private and non-profit settings in the 1980's the hospital again looked to the needs of the community and made new plans.

Only six years after the first hospice was started in this country WMH's Palliative Care Unit became the first inpatient hospice program in Western Massachusetts. It is a sixteen-bed unit for terminally ill patients most of whom have advanced cancer or end-stage organ failure. Early in the 1980's the unit began to accept terminally ill AIDS patients. As the epidemic progressed, we have been accepting more people dying of complications of AIDS. My goal as an internist is symptom and pain control. The Palliative Care Unit has been an education in this regard; I now appreciate how complex and successful aggressive pain management can be.

Palliative care requires the internist to abandon more traditional goals and to consider therapeutic options in a different way. The goal changes from cure and prolongation of life to comfort and preservation of dignity. Pain medications are the hallmark of such care. But what about antibiotics, IV's, blood transfusions, surgery and radiation therapy? I have learned that any of these (or none of these) may play a role in the palliative care of a dying patient. I routinely ignore sepsis but almost always treat cystitis because of potential discomfort. I never use IV's to hydrate a dying patient, but would not hesitate to use an IV if it were the best route for morphine. Palliative blood transfusions can alleviate dyspnea in the leukemic patient but it is not always clear when the transfusion may bring an unwelcome prolongation of the process of dying. Surgery and radiation therapy may easily advance the goal of patient comfort; I have recently had terminally

ill patients who have had (in day surgery) a repair of persistent peri-rectal abscess, a circumcision, and a palliative mastectomy, as well as a patient who elected to pursue a five-week course of radiation therapy (and three who chose not to). Therapeutics are the business of the internist; the goals in the chronic setting require new interpretations of therapeutics.

The challenge of long term care of the Alzheimer patient calls on the physician to adapt the skills of general internal medicine to the needs and goals of patients and families struggling with the prolonged and depressing care of the demented elderly person. One may argue that an Alzheimer unit is a hospice unit in slow motion and the hopeless, terminal prognosis of Alzheimer's Disease leads one to readily adopt a palliative approach. For the internist faced with the family on admission day at the Alzheimer Unit the issues are different. Usually the family speaks of doing everything appropriate for the loved one they are reluctantly moving to a specialized unit. But when I speak of what we mean by "appropriate" in the event of a 2 A.M. myocardial infarction the plan is never clear. I ask, "If your mother were to have a severe heart attack requiring intensive care, should I send her to another hospital's intensive care unit or treat her in the familiar but limited (IV morphine and oxygen) setting of WMH? What would SHE want? Did she ever talk about these things? Usually the answer is somewhere between the extremes of aggressive ICU care and simple comfort care; the challenge is to create the best plan for each patient and family.

As the Palliative Care Unit has taught me about morphine and Dilaudid® (and Trilisate®) so the Alzheimer Unit has finally made me deal with Haldol® (and Buspar® and Stelazine®). The great GERIATRIC TRUTH that miniscule doses of everyting are best IS true: the optimal starting dose of Haldol® (when all other possiblilites are exhausted) is 0.25mg. po bid. A more important truth is that minimal medication and minimal restraint and optimally happy patients are possible only insofar as a people-intensive (family, volunteers, nursing staff, anyone in sight) care plan can be devised. For me as an internist, mastering some of the twilight zone of psychotropic therapeutics has made it possible for me to devise a care plan that allows for some of these Alzheimer patients to go swimming in the summer and to go out to eat with the activities groups more often than I do. I still have questions with no answers. Should I

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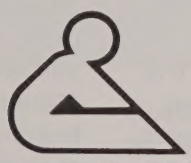

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## Internal Medicine At WMH

*Continued from previous page*

work-up a finding of weight loss and occult positive blood when I know the family feels care should be limited to WMH? Should I do routine sigmoidoscopy or mammogram in an Alzheimer patient whose family knows she would elect limited care? Should I do a CT scan of an Alzhiemer patient with new seizures when the seizures may be due to Alzheimer's or to something else? I have now treated two cases of DVT with aspirin and coumadin and no heparin and both were complete cures.

There are two units for patients with chronic neurologic illness; one, for older patients with stroke and devastating illness and injury; the other, for younger patients with multiple sclerosis, Huntington's Disease, amyotrophic lateral sclerosis and other severe chronic disease. The challenge for the internist is to provide optimal medical care in the context of variably dismal prognoses and the variable life choices of the residents. What creates special problems for the internist is the fact that for these patients the hospital is their home. They live at WMH for years. So problems that are not problems at acute care hospitals loom large in a chronic facility. I recently chaired a meeting of the Infection Control Committee which resulted in a heated debate about the issue of fried eggs. The increasing incidence of Salmonella-infected chickens and eggs means it is much more hazardous to cook fried or soft-boiled eggs than to cook hard-boiled or pasteurized scrambled. But if your patients live at the hospital month after month, year after year, and crave fried eggs and bacon, one must consider whether there are safe approaches to fried eggs for those whose pleasures in life are few. (Answer: inconclusive; we are doing a trial of cooking and measuring the temperature of the yolk.)

The fifth unit is the Coma Unit, now the oldest unit in the hospital, dating from 1977. Approximately twenty patients in persistent vegetative state or other forms of permanent unconsciousness reside there; some have been there for more than a decade. Patients need total nursing care. An active Skin Tissue Breakdown Committee keeps everyone aware of the state-of-the-art approaches to decubitus ulcer prevention and healing. Long term nutritional support is routine. As on other chronic units it is the internist whose setting of goals, elaboration of options, assessment of prognoses, teaching of staff and communication with family, set the tone and agenda of the whole operation.

Western Massachusetts Hospital has six internists caring for these patients. Dr. Chabilal Neergheen has a private practice in internal medicine and nephrology. Dr. Mary King just finished her infectious disease fellowship and consults in several Hartford hospitals. Dr. Robert McGovern has a private practice in allergy and internal medicine. Dr. Barbara Sullivan teaches and practices at the Neighborhood Health Center clinic of Baystate Medical Center. Dr. Kevin Hinchey is now Chief Resident in Medicine at Baystate. I am the only full time physician. The others choose to spend part of their time and skill caring for those whose lives and comfort depend on the chronic daily care of the general internist. They often come in the early morning or evenings and weekends. Without their dedication Western Massachusetts' lone public health hospital would not be able to provide the throughful care necessary for the chronically ill and dying patients who live there.■

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# Balancing Service and Education in Residency Training

*Jack McCue, M.D., is Vice Chairman of the Department of Internal Medicine at Baystate Medical Center, and directs the Internal Medicine Residency Program.*

Medical residents work and learn in uniquely complex, ambiguous circumstances: As house doctors they work as paid hospital employees, yet they continue as fulltime students in an educational process that began for most of them in the first years of college. Historically they have also served as apprentices and protegees of senior physicians who act as mentors, evalutate their skills and abilities, and assist them in obtaining future employment and subspecialty training. A majority of residents, after completing their first year of training, also "moonlight" as full licensed professionals outside the hospital in which they receive their education and training. That conflict and confusion among service, educational, professional, and employment obligations and expectations should occur is not surprising.

**Excellent medical residency programs strive for a creative balance between service obligations and educational opportunities.**

Excellent medical residency programs strive for a creative balance between service obligations and educational opportunities, to enable residents to practice medicine as independently as possible, fulfilling the professional role to which their education and training entitle them, but with the protection to which students and apprentices are entitled. Mutual adherence to fundamental guidelines of fairness and personal responsibility by residents and their employers, mentors, and teachers can help avoid much of the tension and conflict that has been created by the competing demands of work and learning during residency training.

## Residents As Employees

For most medical residents, internship is their first real job, and by most standards, it is not a very good job. They are hired as temporary employees in large corporations that assume little or no responsibility for their long-term well-being. On the other hand, residents are not necessarily good employees: Most have not had permanent jobs before entering medical school, and have not been well prepared by their previous life roles as students and children to be responsible employees.

The paradox, then, that residents are underpaid and often undervalued temporary employees—who are not seriously considered by their employers, mentors, or themselves to be employees—illustrates well the uniquely ambiguous nature of residency training.

## Residents As Students

Much of the important content of residency education resembles more on-the-job training than professional education, and it can only be taught by having residents assume patient care responsibilities: Organizational skills, such as effective coordination of services by colleagues or paraprofessionals; cognitive skills, such as learning how to reason carefully or make decisions with incomplete data, or how to access clinical information from a daunting variety of sources; humanistic and behavioral skills that permit physicians to deal effectively with stressful conflicts in personal, economic, or legal interests. Residency programs that teach

*Continued on next page*

## Residency Training

*Continued from previous page*

the knowledge base of medical practice, but do not allow residents to function independently under faculty guidance will not teach these skills well; in contrast, programs that have residents assume excessive patient care responsibilities, but do not establish a formal educational structure around those activities, will not teach the knowledge base of internal medicine well.

The educational activity to which residency programs devote the largest commitment of time—attending rounds—can be cited as an example of the conflicts among education, service, and personal needs in resident medical education. We ask residents to acquire medical knowlege by listening to attending physicians discussing a clinical case about which they may know little or nothing in advance, and which is chosen because the resident or attending is responsible for the patient's care and not because it illustrates important educational issues. The environment may be noisy and ill-equiped for learning, lacking even basic audio-visual equipment. The 5 to 10 participants in attending rounds range from third year medical students to third year residents to third year fellows, and may include paraprofessionals as well. Some of the students and residents may not have slept for 30 hours, and are periodically interrupted by pages or personal summons by nurses.

There is limited access to factual information beyond the memories of the participants, and the ultimate focus of the discussion—the patient—may be ignored, uncooperative, or unavailable. Yet the conclusions of the discussion may have a profound effect on the patient's care, despite the explicitly defined purpose of attending rounds as an exclusively educational event, or the conclusions may be overruled and ignored by the patient's personal physician or a consultant.

### The Value Of Learning By Doing

An unavoidable difficulty in a discussion of residency training is that the distinction between working and learning is necessarily arbitrary—in fact, many of the assessment, analytic, and procedural skills of medical practice cannot be learned well without the opportunity to use them independently. In addition, the factual medical knowledge acquired from assuming responsibility for the care of a patient with a disease is more likely to be retained and to be useful than a similar effort studying about that disease in books and journals.

Professionalism and the commitment to public service probably cannot be learned except by doing. Passive observation of mentors exhibiting the values and standards of internal medicine as a profession is not adequate as an educational experience—residents must have the opportunity to demonstrate those behaviors and values in circumstances that permit them to assume responsibility for their behaviors.

Public service is an example of an important dimension of professionalism that may be best learned by doing. The opportunities residency training affords residents, who provide much of the medical care for the poor and disadvantaged in public and private hospitals and clinics, to learn first hand the rewards and frustrations of serving the disadvantaged should not be dismissed lightly. Public service is an important justification for government support of expensive medical education and training, and it is an enduring source of professional pride for practicing physicians to have served the poor selflessly during their years of residency training.

### Guidelines For Balancing Service And Education

**1.** The work of the resident is first and foremost the acquisition of an education in the knowledge, skills, and values of the practice of internal medicine. All competing demands and requirements of residency training must be judged against this simple benchmark. Residents should not be asked, therefore, to do work that has little or no benefit to the furtherance of their education, does not allow them to practice independently as a professional, or permit them to provide public service as a professional. Examples of work that does not meet these criteria include:

**a.** Admitting and caring for other phyaicians' patients admitted specifically for diagnostic procedures (e.g. coronary arteriography), therapeutic procedures (e.g. placement of feeding tubes, angioplasty, vascular fistula placement), or implementation of predetermined therapeutic regimens (e.g. cancer chemotherapy).

**b.** Nonphysician work. Examples of nonphysician work, some of which residents are asked to perform in the majority of training programs, includ clerical duties, scheduling of appointments and laboratory tests, arranging for consultations, phelebotomy, performance of minor laboratory tests, patient or specimen transport, filing of reports in patient charts, and minor nursing duties. A suitable test to determine whether residents may be asked to do nonphysician

work is whether attending physicians and faculty are also required to perform those same tasks for their patients.

**c.** Care for other physicians' patients admitted for nonmedical reasons. Examples include caring for patients before or after surgical procedures when there are no unstable medical conditions for which residents may assume independent responsibility, or admitting and caring for patients whose primary reason of hospitalization is observation to determine whether a surgical or other procedure is needed (e.g. epistaxis, dependent ulcers, or severe burns).

**d.** Care for other physicians' patients whose hospitalization is dictated only by social, financial, or environmental crisis. Examples include patients admitted to facilitate transfer to nursing homes or homeless or destitute patients with no medical problems.

**2.** Residents who are asked to assume the obligations of a professional must be accorded the respect and privileges accorded attending physicians and faculty. If all physicians in a teaching hospital are treated similarly, education will be carried out in an atmosphere of mutual professional respect and mentoring that will benefit attendings and residents alike. If a policy of according all physicians equal status is strictly adhered to, the risk that job responsibilities will interfere with, rather than promote, education will be minimized.

**3.** Working conditions that impair residents' abilities to provide high quality patient care such as long hours without rest, lack of adequate backup for help or consultation, or demands for residents to do clerical or scut work at the expense of education or patient care is exploitative. Excessive or unpredictable work loads inhibit learning, promote distrust among faculty and residents, lead to the practice of self-protective and unprofessional behaviors, and may result in poor medical care.

**4.** "Service" within the context of providing patient care in the context of a meaningful patient-physician relationship, especially to poor or disadvantaged patients, is an educationally and professionally beneficial experience. Residency programs that ask residents to care for medically difficult and psychosocially demanding populations, however, are obligated to provide proper preparation, education, and backup.

**5.** The curriculum of the residency years must be determined independently of the service needs of the institution. The numbers of months accorded to ward, critical care, ambulatory, and elective experiences must be determined by the educational needs of individual residents and the educational opportunities provided by those experiences.

**6.** Residents should be regarded as postdoctoral students who are encouraged to take an active role in the development and design of their individual curriculum. In addition, they must be allowed to evaluate and, within the limits of institutional resources, choose their teachers. Just as a postdoctoral student in the arts and sciences may choose courses and teachers that offer the best educational opportunities, so must residents be able to take into account the educational benefits and resources when choices are available.

**7.** Residency education must also give residents a better understanding of the realities of modern medical economics, hospital management, and limitation of access to health care for the poor and disadvantaged that impact the resources available for medical care and medical education. Discussion of how society deals with limited resources, and how priorities within the residency program, institution, and society influence residency education will make residents more understanding participants in the process by which hospitals and clinics provide care.

Hence, while their primary goals must be personal and educational, residents must be aware of their indebtedness and obligations to their employers and community for providing them the opportunity to acquire a professional education, and how as medical residents they fit into the functioning of the hospital and its community as a whole. ■

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# General Internal Medicine:

## A Practitioner Reflects

*John A. Collins, M.D. is an internist at Medical West Health Plan.*

In July of 1980, having completed a residency in General Internal Medicine at Upstate Medical Center in Syracuse, NY, I returned to Southern New England to join a small staff model HMO in Chicopee, Massachusetts, called Medical West. My considerations included wanting to be close to family, wanting to be in a group setting, and wanting to be able to develop a longitudinal outpatient oriented practice with access to a tertiary center preferably with opportunities for teaching.

**If General Internal Medicine has a major failing, I believe it consists in our inability to enthusiastically share the personal satisfaction we receive from our patients with our colleagues.**

It hardly seems like eleven years have passed. From three generalists and one specialty internist in 1980 for a patient base of 8,000, our group has grown to include 27 generalists and 14 specialty internists, 29 of whom have been practicing in greater Springfield for more than five years. We are now collectively caring for over 70,000 residents of greater Springfield. The fact that one of the specialties we now have on a full-time basis, namely angioplasty, did not even exist in 1980, helps to underscore the magnitude of the changes that have taken place in medicine during the last decade. There can be no underestimating the influence these changes have had in the field of General Internal Medicine.

In 1980, the General Internist was able to be more actively in control of his/her patient than today. Respirator managment in the ICU/CCU milieu was the province of the generalist with perhaps a pulmonary consultant—intensivists did not exist in Springfield in 1980. In a variety of other specialty areas, the evolution of practice has tended to diminish what the general internist routinely handles. Some would bemoan this type of change and nostalgically long for the "good old days." Others breath a sigh of

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relief and willingly pass on responsibilites they handled infrequently and therefore were uncomfortable handling.

It is all too easy, however, to miss the point that the source of practice satisfaction for the generalist no longer comes from technologic proficiency but from the effective coordination of complex medical issues within the context of the individual's social and family situation. The AIDS epidemic, the issues of advanced directives brought into focus by the Health Care Proxy legislation and the issues of erythropoietin, MRI applications and minimally invasive technology all come to mind. The role of care coordination and longitudinal care management becomes all the more important when dealing with limited resources and the need to apply advanced technology in a cost-effective and care appropriate way. General Internal Medicine is in a position to meet this challenge as no other specialty can.

If General Internal Medicine has a major failing, I believe it consists in our inability to enthusiastically share the personal satisfaction we receive from our patients with our colleagues, residents and students. We live in a time in Medicine when the best and brightest seem to elect career paths other than General Internal Medicine. To the degree that we overemphasize our frustrations and fail to acknowledge our satisfactions, our students will continue to pursue the allure of the high tech.

I'm proud to be a generalist and it is a pleasure to be associated with a quality group of generalists within the multispecialty group practice setting and in the community, as a whole. As we attempt to build on the respect that General Internist have enjoyed, we need to recognize that we must become our own advocates. If we don't, no one else will.■

## In Memoriam

**Frederick C. Schwendenmann, M.D.**, passed away on September 17. He graduated from Indiana University of Medical School. He was the medical director for several local nursing homes, and practiced on the staffs of Baystate, Mercy, and Ludlow Hospitals. He is survived by his wife Dorothy, sons Todd and Mark, and daughters Dana, Amy, and Heidi.


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# "I have never gotten used to people dying. And I don't want to get used to it."

Dr. Aliza Lifshitz, Internist, Los Angeles, California, Member, American Medical Association

Patients come to physicians for many reasons. Beyond relief from pain, they seek compassion, empathy and support. AIDS patients receive all of these and more from Dr. Aliza Lifshitz.

Born and raised in Mexico and educated at one of Mexico City's finest medical schools, Dr. Lifshitz now serves the Hispanic community in Southern California. Over a third of her patients have tested HIV positive. Most live below the poverty level. Many are illegal aliens.

"I never forget what it means to be a doctor, and what it means is embodied in the Principles of Medical Ethics of the American Medical Association (AMA)," states Dr. Lifshitz.

You are invited to join Dr. Lifshitz and to join with her in her efforts to bring quality health care to those in need. Become a member of the American Medical Association today.

Members of the AMA are encouraged to join their state, county and specialty societies.

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# "A Healthy Future"

## Signature Drive Launched For Intiative Petition To Prevent Childhood Tobacco Use

In an effort to keep Massachusetts' children from becoming addicted to cigarettes, a coalition of health organizations and businesses has launched a campaign to gather more than 150,000 signatures by November 20 to help keep cigarettes out of the hands of minors.

The Massachusetts' Coalition for a Healthy Future is seeking to place a question on the November 1992 ballot which, if approved by voters, would establish a health protection fund to keep children from starting to smoke. More than 100,000 Massachusetts children alive today will eventually be killed by cancer, heart disease, and other illness caused by tobacco use.

In spite of the fact that selling to minors is illegal in Massachusetts, 90 percent of today's adult smokers became addicted to tobacco before their 19th birthday, and 60 percent were regular smokers by age 14. According to the Massachusetts Department of Public Health, seven percent of current sixth graders are confirmed smokers. Through vending machines and inattentive sales clerks, children can usually buy cigarettes easily. The tobacco industry sells $1 billion worth of cigarettes to children each year.

For every 10 percent increase in the price of cigarettes, 12 percent fewer children will take up smoking, and four percent of adults will quit, according to the Massachusetts Department of Public Health. A similar initiative petition which took effect in California in 1989 has so far resulted in a 14 percent drop in cigarette consumption.

The health protection fund, supported by a 25¢ increase in the cigarette excise tax, would have the double benefit of increasing the price of cigarettes to make them less accessible to children, while funding health programs throughout the Commonwealth. Income would be used to fund programs including comprehensive health education in Massachusetts public schools, to teach children about health, smoking prevention, and methods of quitting. Prenatal and maternal health programs in community health centers would also be funded, cautioning women about the damage smoking can do to a fetus. Pregnant women who smoke are more likely to give birth prematurely, and to have babies who are small and have more health problems.

The Massachusetts Coalition for a Healthy Future is led by the American Cancer Society's Massachusetts Division, the Massachusetts Medical Society, and Blue Cross Blue Shield of Massachusetts. Members include nursing and public health groups, businesses, women's groups, and minority advocacy organizations. The Coalition is seeking 1,500 volunteers to gather 100 signatures each before November 20.

"We hope every voter who doesn't want his or her child to take up smoking will sign a petition this fall," said Blake Cady, M.D., Chairman of the Massachusetts Coalition for a Healthy Future.

"The tobacco industry desperately needs young kids to replace lost customers," Dr. Cady said. "More than 3,000 of their best customers die or quit smoking every day, and children comprise the vast majority of their new replacement customers."

Smoking is the leading preventable cause of disease and death in the United States, responsible for more than 434,000 premature deaths each year.

Funds to support the Coaltition's initiative petition campaign will be raised independently of the members' usual programs and activities. The ongoing research, education, and service programs of the American Cancer Society and other Coalition members are not affected by the campaign. Contributors and volunteers seeking further information should call the Coalition at 1-800-952-7664.■

# Correspondence

*Garry Hough III, M.D., sent the following letter to Dr. Murray Watnick, who has sent it on to us. We are pleased to reprint an excerpt.*

Dr. Murray Watnick, M.D.
Noble Hospital
Westfield, MA 01085

Dear Murray,

Congratulations on your article, "Radiology for the People" in the Hampden Hippocrat which arrived at my island retreat today. Having worked with Orthopaedics Overseas in several third world countries, I know the truth of which you speak. The 60% inoperable X-ray machines is a conservative estimate. It makes practicing orthopedics kind of tough. We did not have a portable unit anywhere in the hospital in my last tour in Malawi, so our "intraoperative" X-rays were done 2-3 days post-op. But there was a C-arm in the X-ray department, only it didn't work.

The need for BRS is very real. Is anybody in the world making them? Your article states the need very well. Could I have about 20 reprints to hand out in early September at the Orthopaedics Overseas Board of Directors meeting? I don't even know if the Hippocrat does reprints, but it sure would be nice. If it is not possible, I'll do the best I can with a copier.

It is nice to have an excuse to write you. I am enjoying retirement, but I read the Hippocrat and the MMS News before anything else. This last issue was especially good, with the new format and Mark's excellent editorial, I am pleased to hear that Mass. is getting to be a more friendly place in which to practice, but I hope the New England economy turns up pretty soon. Gov. Weld's latest cuts sound real tough.■

*Garry Hough III, M.D.*


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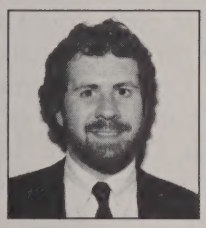
# The American College of Physicians:

## Access to Health Care and Plan for Change



*Robert Fishman, D.O., F.A.C.P., the author of the following article, practicies Internal Medicine in South Hadley, and is a member of the American College of Physicians Health Policy Committee.*

In May of 1990, The American College of Physicians published a position paper in the Annals of Internal Medicine entitled, "Access to Health Care". Four major problems faced by patients and physicians in the present health care system were highlighted: Inadequate access to health care, inadequate health insurance protection, continued rise in health care costs, and a burdensome system for patients, their families, and physicians. The ACP also identified criteria for a better system in this paper. These included benefits, financing, organization and delivery, and satisfaction. In further defining these broad categories, it was felt that a uniform minimum package of benefits should be available for all citizens, with coverage decisions based on clinical effectiveness; that coverage and benefits should be portable and continuous: and that a mechanism should be instituted for determining the scope of benefits. Financing needed to be developed that would eliminate financial barriers to obtaining needed care. A mechanism for controlling costs needed to be developed, as well as a way of incorporating current revenue sources into a new system. This system needed to be flexible, with incentives for patients to seek preventive health care and pursue healthy life styles.

**The current American health care system is severely flawed and irreparable.**

It was felt that the current American health care system are severly flawed and irreparable. Too many people were uninsured or underinsured. Too much money was being spent in the administration of the health care system, and there were too many payers in the system, making the hope for a uniform fee structure distant.

While this position paper outlined the problems in the health care system, specific solutions were not elucidated, because they were not readily at hand. Broad criteria for a better system were given, as mentioned above, but it was felt that more information would be necessary before the ACP would be ready to offer concrete solutions. To this end, the ACP presented the position paper on Access to Health Care to as many practicing physicians across the country as possible. After the presentations, questionaires were distributed for completion and return to the members of the health policy committees and to the governors.

In my role as a member of the Massachusetts American College of Physicians Health Policy Committee, I spoke this year at Holyoke Hospital, Baystate Medical Center, and Cooley-Dickinson Hospital, on the Access to Care Project. In a questionnaire soliciting the opinions and viewpoints of my audience, I asked what they felt were the health care policies in Massachusetts most in need of reform. I additionally asked for recommendations for reform of those policies. Many respondents felt that a no-fault type of malpractice insurance was needed, along with limits to malpractice awards; that health insurance for the poor and unemployed was needed; that rationing of unnecessary care as well as reform of Blue Cross and Blue Shield were needed. A few respondents

*Continued on next page*

## ACP Plan

*Continued from previous page*

felt that the mandatory assignments of Blue Shield needed to be freed up. It was felt that health care dollars needed to be prioritized, based on outcome data. Many respondents recommended lowering of administrative costs of health insurance, a better method of distributing and paying for Medicaid patients, and universal insurance coverage, possibly from a single party payer. Some respondents felt that the system needed to change from a high-technology, high cost care system to one which valued and paid for wellness and cost effective care. Education of patients and preventive care needed to be emphasized. It was felt that uniform fee schedules should be instituted, that HMO's should see a proportion of the Medicaid population and of uninsured patients, and one respondent felt that all peer reviewers should have practiced medicine similar to the areas they are reviewing. All of the responses were collated and a report was sent by me to the Massachusetts ACP governor, Dr. John T. Harrington, of Newton-Wellesley Hospital. He presented this and other information at the Massachusetts Chapter American College of Physicians Scientific Meeting on Saturday and Sunday, October 19, and 20, 1991, at Jiminy Peak in Hancock, MA. Additionally, this information will be incorporated in the overall data pool being collected nationally by the American College of Physicians.

The next phase in the ACP's task of reassessing the American Health Care System has been a draft working paper, "Plan for Change". This paper was distributed to thousands of College members, who have expressed an interest in the access issue, in August of 1991. Accompanying this draft working paper is a six page questionnaire to be answered and returned to the respective governors for integration and forwarding to the National Health and Public Policy Committee. Based on this input, and that of others, a revised draft will be developed by the health and Public Policy Committee and distributed at the ACP's Annual Session in San Diego in March of 1992.

In the draft working paper, "A Plan for Change", it is proposed that there be universal coverage of all medically appropriate health costs for all Americans. These costs would be paid through either private, employment based plans via employer mandate or a single public plan. Beneficiaries of the public plan would include all people over the age of 60, all poor, and all others not covered by the private plans. The public plan would also provide for coverage for all costs above $25,000 per person per year. Cost containment would be provided for by a combination of competition and regulation. Only care that is medically appropriate under professionally developed guidelines would be paid for. Price competition would occur at the point of purchase by the plan sponsor. Value competition would occur at the point of purchase by the plan sponsor and at point of service. Negotiated fee schedules, based on a strict resource based relative value scale, would be established for all services. All payers would pay the same amount for the same service per institution and physician. Administrative costs would be diminished by developing a single electronic claim and data form per encounter, with a single point of contact for all payment despite the plan used. Utilization review would be performed under pattern monitoring, not case by case. In addition, the malpractice system would be reformed and would become completely no-fault for all medically associated injuries. Financing for this system would be from employers, employees, the poor, the self-employed, and in part, those

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over age 60. Medical education would be separately funded; health care professional supply and distribution would be adjusted by training funds and loan forgiveness programs, and an extensive program of public education would be embarked upon to enhance the value consciousness of the public and to change expectations.

The American College of Physicians has led the way in speaking out against the current health care system, pointing out its flaws and asking the hard questions. In the wake of the Access to Care position paper, many other medical institutions have also called for a change in the American health care system. After polling practicing physicians extensively over the past year, the ACP, through its draft paper, "A Plan for Change", is beginning to formulate its own frame work for a new health care for all Americans with cost shifting away from administrative expense towards patient care priorities. The ACP is committed to participating in the evolution of our current health care system. It cannot do this without continued input from practicing physicians. Working together, we have an opportunity to shape the landscape for our future. For further information, please contact me at (413) 538-5620 or Dr. John T. Harrington at (617) 243-5436.■


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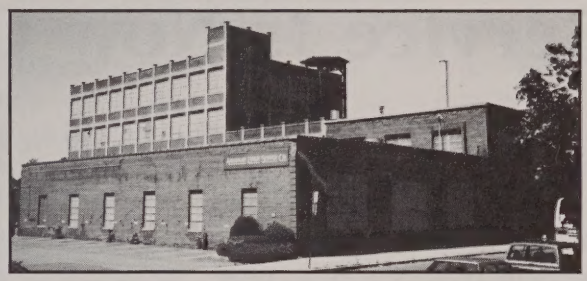

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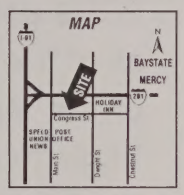


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# Professional Credentials Verification Service Is Now Operational

In the May-June Issue of the **Hippocrat**, you may recall reading about the development of the Massachusetts Medical Society's new service, the Professional Credentials Verification Service. We are pleased to announce that the Professional Credentials Verification Service (PCVS) is now fully operational. PCVS is processing both appointments and reappointment applications for subscribing health-care facilities.

As you may recollect, PCVS developed and tested a standardized application for staff membership. Six hospitals participated in the pilot phase and all six have decided to contract with PCVS. Three of these hospitals are in Western Massachusetts: Mercy, Noble and Providence.

PCVS provides many benefits for physicians and health-care facilities. PCVS will collect and verify all the necessary background information (physicians licenses, educational background, practice history, liability insurance, National Practitioner Data Bank) and forward certified copies of each document to the medical staff office. Individual physicians are pleased with the service because it reduces their workload. With PCVS, the physician needs to complete only one application for staff membership. Physicians have made the following comments after completing the standardized application form: "The visual appeal and readability are much improved over the norm to which I have been exposed" and it took only "10 minutes to complete."

**The information which PCVS gathers meets all of the requirements of the MA Board of Registration in Medicine Regulations, JCAHO Accreditation Standards, Department of Public Health Regulations, and HCFA standards.**

A medical staff coordinator already participating in PCVS has expressed her pleasure in the content and timeliness of all the information which PCVS is providing to her facility. Freed of the time-consuming burden of writing

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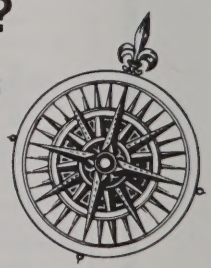

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to multiple sources to verify the information on each physician, she says she can now focus on the reveiw and interpretation of documents for credentialing committee meetings and provide the necessary support to the members of that credentialing committee.

The information which PCVS gathers meets all of the requiremtns of the MA Board of Registration in Medicine Regulations, JCAHO Accreditation Standards, Department of Public Health Regulations and HCFA standards.

PCVS is now ready to accept membership from health-care facilities state-wide. They expect that there will be a substantial demand for the service. In order to maintain the quality of responsiveness which was developed during the pilot phase, there will be restrictions on the number of facilities signing up each month. Facilities who have previously expressed an interest in the service will be given the first opportunity to participate.

PCVS contracts directly with your health-care facility. The processing for $125 for new applicants and $25 for reappointments. A one-time facility membership fee of $3000 (for hospitals with less than 500 M.D.'s) is charged to cover the costs of transferring the facility's existing physician credentialing data into the PCVS system.

If you and your facility are seriously interested in joining Professional Credentials Verification Service and would like to be give priority status in the timeliness of your enrollment, you may wish to have your administrator contact PCVS to indicate your plan.

Should you need additional information, PCVS staff are also available to come to your facility to further discuss the service with physicians and administrators. To arrange a meeting or answer any further questions, please contact Ms. Audrey DeLoffi, PCVS Administrator, at (617) 893-4610, Ext. 1447. ■

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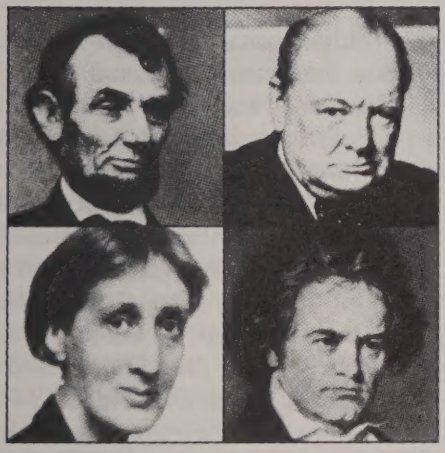

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# Arnold Relman:

## Still with Things to Do in Medicine

*Arnold Relman graduated from Columbia University College of Physicians and Surgeons in 1945. A bout with tuberculosis delayed the completion of his internship at Yale University and disqualified him from military service. He came to Boston in 1949 as a fellow at Boston University with Dr. Charles Burnett in the speciality that would ultimately be called nephrology in the 1960's. When Dr. Burnett left to help start a new medical school in Texas, Dr. Relman was asked to head the "metabolic division" and remained at that post, running the laboratory and directing the clinics until 1969, when he left to become chief of medicine at the Unviersity of Pennsylvania. He recently stepped down as editor of the New England Journal of Medicine after a very successful fourteen year tenure.*

*Dr. Relman has been an outspoken proponent of the need for a sea change in the organization of health care delivery. He continues his efforts to bring about that change from the Department of Medicine at the Brigham and Women's Hospital, where he was interviewed by the HIPPOCRAT.*

**Q What changes have you seen in the way in which medical education has been financed over the years?**

**A** The major portion of medical teaching in the 1950's and even in the 1960's was performed by voluntary, part-time faculty who made their living in private practice. There was a smaller cadre of full time faculty on salary and they also did some teaching. As the research establishment expanded with the availability more funding for research, there was a big expansion of full time faculty in the 1960's and the 1970's. When I was at Boston University and later at the University of Pennsylvania, people from the NIH would come around the lab and ask whenever you needed help. The limitation was not on money, it was on brains and on finding people with good ideas who could run good programs and do good research. Each year the NIH budget would go up and a large amount of that money went to finance medical education, although it wasn't specifically earmarked for that.

**Q What caused this happy situation to change?**

**A** The NIH budget became tighter and competition for grants increased. If the medical schools wanted to continue to depend on voluntary faculty for teaching, there wouldn't have been this crunch. Most schools had decided for better or for worse that the bulk of the teachers should be full time. The budget for medical research in this country goes up every year. Competition for research money developed because the number of people seeking grants increased and the cost of doing research in terms of materials and equipment increased. It became apparent by the late 1970's and certainly in the 1980's, that a large full-time clinical faculty couldn't be paid from research grants, by increases in tuition alone or by dipping into the institutional endowment. Medical schools are the most luxuriously staffed of any graduate educational faculties. So the medical schools turned to organizing their clinical faculties into faculty practice plans to generate the needed revenue.

**Q Didn't the success of this strategy depend on the fact that there were many more potential paying patients presenting themselves for care in the 1980's then there were in the 1960s?**

**A** Yes. Sixty percent of all the free care in this country in the 1960's was provided by private, nonpublic community hospitals on a charity basis. The hospitals charged what the patients could afford and the doctors didn't charge anything at all. They cross-subsidized their own costs by charging those that could afford to pay what the traffic would bear.

**Q So there was a system of taking care of those who couldn't pay for care before the explosion of payment for health care by government and insurance companies?**

**A** There is no question that the advent of Medicare increased access to health care for a large number of people. Some people didn't feel comfortable at all throwing themselves into the hands of the charity system and they often came when it was finally too late. Also, the charity system wasn't available to everybody. If you were lucky enough to live in an area where there was a public or community hospital, you could be taken care of on an emergency basis. The care wasn't ideal; it wasn't continuing care and there wasn't much preventative care. Organized medicine and the AMA opposed the introduction of Medicare and Medicaid because they were afraid that government would control the doctors. That concern was assuaged when government said that it wouldn't interfere with private practice at all and it would pay what was usual, customary and reasonable for the care. All that government would require was evidence that the service was rendered.

**The reason I direct my efforts toward the medical profession is that I truly believe that if we doctors really wanted to, we could solve this problem.**

**Q What do you think of the concerns of physicians who felt that the arrival of Medicare changed the realtionship between the physician and the patient in a fundamental way?**

**A** There is an important paternalistic streak in medicine that says that good doctors take care of their patients. They see to it that patients get the care they need at whatever charge the patient can manage. There is also—I think it's fair to say—a certain possessiveness about good physicians who feel responsible for their patients and tell them not to worry. These good physicians feel that, "nobody else should have anything to say about the relationship between me and my patient, because that's *MY* patient." That kind of relationship was good but some patients, even when I was a young physician, resented the fact that they were infantilized by the doctor, that they were too dependent on the doctor. They wanted to have more say about how they were going to be treated.

**Q Do you associate the introduction of Medicare with the rise in the cost of health care?**

**A** Yes, in part, but around the time that Medicare was introduced, medicine started to become a lot more specialized and a lot more expensive. Patients started to get a lot more care and doctors made a lot more money. The handwriting was on the wall. Anyone with any common sense could see that specialization, high technology, more and more doctors, and open-ended third party coverage would lead to disastrous inflation in costs. By the late 1970's this became clear to government, which was paying for 40% of the cost of all health care, and to businesses, who were paying for a large percentage of the rest. So in the 1980's you saw a revolt by the payers. One of the first things payers did was to refuse to pay the hospitals for the free care they were dispensing by refusing to pay more than the costs of insured patients.. The second thing was to demand discounts for their insured patients.

**Q Why do you think we are in crisis at this point?**

**A** Because nobody's happy with the system any more and costs just keep going up and up. Patients aren't happy because they have less and less access. In some states you have to be incredibly poor to qualify for Medicaid. Many patients have no insurance at all; others are underinsured. Medicare patients are paying higher co-payments and deductibles. The doctors aren't happy because they're being squeezed and harassed by third party payers. The hospitals aren't happy because they aren't getting paid for poor patients. Yet HHS just projected that by the end of this decade we will be spending 1.6 trillion dollars on health care or 16% of the gross national product.

*Continued on next page*

## Interview Arnold Relman

*Continued from previous page*

**Q I can see why you focus on doctors as having primary responsibility in the expansion of health care costs because they order the tests, or drugs, or procedures. But how about the completely absurd costs of drugs and medical equipment, even simple things like catherers. Doctors don't have any control over that.**

A It's true that doctors don't have any control over the cost of medical equipment and supplies, but for every example you can give of excessive charges of this kind, I can give two examples where doctors are ordering things that are really not essential. They are ordering things because they're afraid they are going to be sued if they don't or because it's economically very attractive for them to do so. Doctors have to assume their responsibilities in this area. They collect only twenty cents of every health care dollar, but their orders and recommendations determine a large part of the rest of the dollar.

**Q People I know say twenty cents isn't enough—why don't we get more? We do all the work; we are the ones who get sued. What about the fat cats in the pharmaceutical industry? Why doesn't Relman go after them?**

A The reason I direct my efforts toward the medical profession is that I truly believe that if we doctors really wanted to, we could solve this problem.

We cannot as a profession simply say: "Go away and leave us alone. We didn't cause the problem and we are not responsible for it and we aren't going to do anything to change. Some one else is going to have to change this." We must realistically look at the evidence for excessive costs and inadequate access and then consider what we could do to deal with the problems. Of course, we will have to work with government and other third party payers.

**Q Don't you believe that those who are paying for the care—namely the government and business—are going to cut the deal with the labor unions and the pharmaceutical companies and the insurance companies to change the system with the patients and doctors largely left out?**

A Exactly! And my point is that since we physicians are at the center of the system, we can have an enormous influence over how resources are allocated. So we physicians have a responsibility to sit down at the table with the people who are cutting the deal and make constructive, realistic and practical suggestions as to how to improve the situation, which will be acceptable to the people who pay. We can't just keep complaining about how we are harassed. We have to take a more constructive view.

**Q So how would you go about building consensus to produce effective change?**

A I believe it isn't helpful to assign blame. The first step is recognize what the problem is. Unfortunately organized medicine is reluctant to look at all sides of the issue and is too defensive about things that make doctors look bad. We have to get over being defensive and then look at the data as objectively as we can. There are many possible solutions. Some of these will be attractive to us, others won't. Some solutions will be attractive to the payers, others will not be. We have to come up with solutions that are acceptable to the public and will enable us to continue to practice good medicine. The public will rally around us when we have demonstrated that our primary concern is to provide good medical services to all those in need, that our own economic welfare is secondary, and what we advocate is truly in the public interest. ■

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*Brigid K. Glackin, M.D.*

# New Members Welcome

Jacques M. Archambault, M.D.
15 Hospital Drive #502
Holyoke, MA 01040

**Born:** July 23, 1948
**Premed:** College Univers-Taire de Rouyn, Canada 1963-1967
**Medical:** University of Montreal 1967-1971
**Internship:** Verdun Hospital, Quebec, Canada 1971-1972
**Residency:** University of Montreal 1972-1976
**Specialty:** Orthopedic Surgery

Justo L. Gonzalez, II, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

**Born:** July 17, 1965
**Premed:** Purdue University, Indiana 1983-1987
**Medical:** University of Puerto Rico School of Medicine 1987-1991
**Internship:** Baystate Medical Center July 1991-Present
**Specialty:** Internal Medicine
**Resident**

James B. Khoury, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

**Born:** August 24, 1959
**Premed:** American University of Beirut 1979-1982
University of Pennsylvania 1982-1983
**Medical:** Temple University 1987
**Internship:** Baystate Medical Center 1987-1988
**Residency:** Baystate Medical Center 1988-1991
**Specialty:** Anesthesiology
**Resident**

William C. R. Seefeld, M.D.
275 Bicentennial Highway
Springfield, MA 01118

**Born:** January 13, 1950
**Premed:** Duke University 1968-1972
**Medical:** Columbia College of Physicians & Surgeons 1981-1985
**Internship:** Danbury Hospital, Connecticut 1985-1986
**Residency:** University of Pittsburgh 1986-1989
**Fellowship:** Childrens' Hospital 1989-1990
**Specialty:** Pediatric Ophthalmology

John A. Holbrook, M.D.
Mercy Hospital
271 Carew Street
Springfield, MA 01104

**Born:** January 22, 1946
**Premed:** Cathedral College 1963-1965
St. Joseph's Seminary 1965-1967
**Medical:** Harvard Medical School 1971-1975
**Internship:** Baystate Medical Center 1975-1976
**Residency:** Baystate Medical Center 1976-1977
1979-1980
**Specialty:** Internal Medicine/Emergency Medicine

James K. Katz, M.D.
Holyoke Hospital
575 Beech Street
Holyoke, MA 01040

**Born:** December 31, 1957
**Premed:** Pennsylvania State University 1976-1978
**Medical:** Jefferson Medical College 1977-1981
**Internship:** Strong Memorial Hospital, New York 1981-1982
**Residency:** Strong Memorial Hospital, New York 1982-1985
**Fellowship:** UMass Medical Center 1985-1986
**Specialty:** Diagnostic Radiology

*Continued on next page*

## New Members Welcome

*Continued from previous page*

Paula J. Legere, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

**Born:** April 23, 1965
**Premed:** Fairfield University, Connecticut 1983-1987
**Medical:** University of Vermont Medical School 1987-1991
**Internship:** Baystate Medical Center July 1991-Present
**Specialty:** General Surgery
**Resident**

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# Hampden Committee Activities

The Executive Committe met on June 18, 1991 and again on September 19, 1991. Highlighting the agenda were the following issues: HDMS House Calls Program in which a panel of HDMS members provided information and answered questions about specific medical topics from the general television viewing audience. The first of these programs was aired on October 20, 1991 at 7:00 p.m. on Channel 22. The subject was cardiology. The program was hosted by Dave Madsen and included a panel of fifteen area cardiologists discussing pertinent subjects and answerng phone-in questions from the viewers. The planning and logistics of this endeavor were handled by the HDMS Public Relations Committee.

There was also a discussion on the training session for the Substance Abuse Program. This program would involve members of HDMS speaking at local area Boys and Girls Clubs on substance abuse.

Another subject that was discussed was the "Role Model" program. This will involve working with the Bar Association and going into the Springfield schools over a period of ten weeks for a half hour each time. A physician and attorney would go together and hold discussions with school children.

With the success of the 1991 Poster Contest held with the Springfield Public School children advocating a cessation of smoking in schools, plans for the 1992 Program were discussed. These will be followed through by the Public Health Committee.

Events that were discussed included the Medical Ethics Seminar held on October 23, 1991. The main speaker was Rev. John Tuohey and the topic was "Heightened Awareness of HIV Related Problems."

On November 1, 1991 there was a program at the Yankee Pedlar in Holyoke. This was for women physicians entitled "Sexual Harassment and Gender Discrimination: A Primer for Women Physicians."

On Friday, November 15, 1991, there will be a cocktail party at the home of Doctor and Mrs. Peter Demos. This will be sponsored by the HDMS Auxiliary and the proceeds will go to the Jefferson Avenue Shelter for Women and Children.

The District Meeting was held on October 1, 1991 at the Delaney House. Two guests who spoke during the business meeting were Theresa M. Theroux, Health Commissioner for the City of Springfield, who discussed the Shigella Epidemic in that City and Scott A. Fox, M.D., Medical Director of Medicaid, who spoke on the proposed evolution of Medicaid to a Managed Care Plan. This was met with mixed emotion and many questions.

United State Congressman Richard E. Neal was scheduled to speak at the Dinner Meeting but unfortunately was unable to attend. In his place, his aide, Kevin Kennedy expressed his regrets.

The main dinner speaker was Attorney Randolph B. Fenninger, Sr. Vice President of MARC Associates from Washington, D.C., who gave a national legislative update. ■


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